Healing Hands Chiropractic, LLC

3 Hall Ave, Wallingford CT 06492 (203)626-9994

AUTO INJURY QUESTIONNAIRE

Name_____ Age_____ Birth Date_____/_____/_____
Sex: □ M □ F
Address_____City_____State_____Zip_____
Home#_____ Cell#_____ Work#_____
Email _____ Who referred you to us? _____ _
Marital Status □ M □ S □ D □ W Number of Children_____ Are you Pregnant? □ Yes □ No
Height_____ Weight_____ Occupation_____ Full Time / Part Time
Employers Name_____ Employers Address_____
Your Auto Ins. Co._____ Policy #_____ Agents Name_____
Do you have Med Pay on Policy? □ Yes □ No □ Unknown Do you have health insurance? □ Yes □ No
NATURE OF ACCIDENT: 1. Date of Accident ___/___/___ 2. In your own words, briefly describe the accident: _____
_____
_____
_____
3. Were you □ Driver □ Front Passenger □ Left rear passenger □ Right rear passenger □ Other_____
4. Who hit who/what? □ You hit other vehicle □ Other vehicle hit you □ You hit object_____
5. Point of impact □ Head-on □ Left Front □ Right Front □ Rear-End □ Left Rear □ Right Rear
6. Your vehicle type □ Car □ Van □ Station Wagon □ Pick-up truck □ SUV □ Other_____
7. What was your vehicle doing at the time of the accident? □ Stopped at an intersection
□ Stopped in traffic □ Stopped at light □ Making a right turn □ Making a left turn □ Parking
□ Proceeding along □ Slowing down □ Accelerating □Other_____
8. The other vehicle type □ Car □ Van □ Station Wagon □ Pick-up truck □ SUV
□ Other_____
9. What was the other vehicle doing at the time of the accident? □ Stopped at an intersection
□ Stopped in traffic □ Stopped at light □ Making a right turn □ Making a left turn □ Parking
□ Proceeding along □ Slowing down □ Accelerating
□ Other_____
10. Did you have a seat belt on? □ Yes □ No Did you have a shoulder harness on? □ Yes □ No
11. What was the direction of your head at time of impact? □ Straight □ Turned Right □ Turned Left
12. How many people were in the car with you? □ None □ One □ Two □ Three □ Four □ Other_____
13. Time of Accident_____ Road conditions at time of accident □ Icy □ Wet □ Sandy □ Dark □ Clean and Dry
14. Visibility at time of Accident □ Poor □ Fair □ Good
15. What was the position your headrest at time of impact? □ Up □ Down □ Unknown □ No head rests
16. Was the head restraint position altered by the impact? □ Yes □ No □ Unknown
17. Did driver side air bags deploy? □ Yes □ No Did passenger side airbags deploy □ Yes □ No
18. What was your hand position on the steering wheel? □ Both hands on □ One hand on
□ Do not recall

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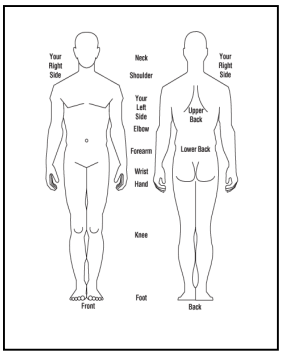
19. Did you have pressure on the brakes? □ Yes □ No □ Do not recall
20. Did you see the accident coming? □ Yes □ No Were you braced for the impact? □ Yes □ No
21. Did your body strike the inside of your vehicle? □ Yes □ No
*If yes, what part of your body?_____hit what part of the vehicle?_____
22. Did your vehicle hit anything else after the crash? _____
23. Did you lose consciousness during the injury □ Yes □ No *If yes, how long_____
24. Did the police show up at the scene? □ Yes □ No Was a report filed? □ Yes □ No
25. Where did you go after the accident? □ Home □ Work □ Hospital ER □ Private Doctor
26. How did you get there? □ Drove self □ Somebody else □ Ambulance □ Police □ Other_____
27. Check off your symptoms right after and/or a few days following:

□ Headache	□ Ringing in ears	□ Neck stiffness
□ Dizziness	□ Chest pain	□ Neck pain
□ Nausea	□ Shortness of breath	□ Nervousness
□ Diarrhea	□ Mid-back pain	□ Tension
□ Anxious	□ Cold hands	□ Toe numbness
□ Constipation	□ Fainting	□ Irritability
□ Sleep trouble	□ Depression	□ Other_____
□ Low back pain	□ Pain behind eyes	___
□ Cold feet	□ Loss of smell	
□ Confusion	□ Hand numbness	
□ Fatigue		

28. If you went to the hospital, were x-rays done? □ Yes □ No Was lab work done? □ Yes □ No
Body parts x-rayed? _____ X-rays revealed? _____ Lab work revealed? _____
29. Treatments: □ Cervical collar □ Ice □ Medications_____
□ Other_____

Primary Complaint: _____
Symptoms appeared: □ Gradually □ Suddenly
How long have you had this pain? _____ Years / Months / Weeks / Days

Mark an X on the picture to the right where you are having pain or discomfort --->
Type of pain: □Aching □Burning □Diffused □ Dull □Numbness □Sharp □Shooting □Throbbing □Tightness □Tingling
How frequently do you have this pain? □Constant □Frequent □Intermittent □Occasional
Symptoms are aggravated by: _____
Symptoms are reduced by: _____
Rate the severity of your pain (Circle one): 1 2 3 4 5 6 7 8 9 10
What time of day is the pain most noticeable? _____
Secondary Complaint:_____
Symptoms appeared: □ Gradually □ Suddenly
How long have you had this pain? _____ Years / Months / Weeks / Days



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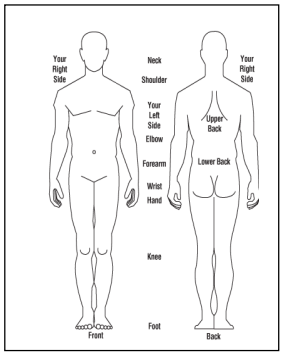
Mark an X on the picture to the right where you are having pain or discomfort --->

Type of pain: □Aching □Burning □Diffused □ Dull □Numbness □Sharp □Shooting □Throbbing □Tightness □Tingling

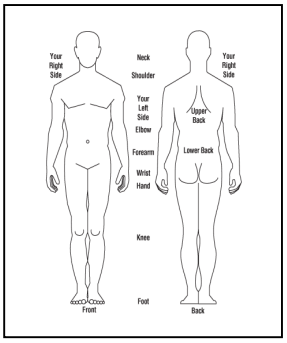


How frequently do you have this pain? □Constant □Frequent □Intermittent □Occasional
Symptoms are aggravated by: _____
Symptoms are reduced by: _____
Rate the severity of your pain (Circle one): 1 2 3 4 5 6 7 8 9 10
What time of day is the pain most noticeable? _____
Additional Complaint: _____

Third Complaint_____

Mark an X on the picture to the right where you are having pain or discomfort --->

Type of pain: □Aching □Burning □Diffused □ Dull □Numbness □Sharp □Shooting □Throbbing □Tightness □Tingling



How frequently do you have this pain? □Constant □Frequent □Intermittent □Occasional
Symptoms are aggravated by: _____
Symptoms are reduced by: _____
Rate the severity of your pain (Circle one): 1 2 3 4 5 6 7 8 9 10
What time of day is the pain most noticeable? _____
Additional Complaint: _____

HAVE YOU SEEN ANY OTHER DOCTORS FOR THIS CONDITION?

PLEASE LIST ALL SURGERIES YOU HAVE HAD Type_____ When_____
Doctor_____ Type_____ When_____
Doctor_____ Type_____ When_____

PLEASE LIST ANY PREVIOUS ACCIDENTS/FALLS What_____
When_____ What_____ When_____
Remarks_____

Physicians or health care practitioners seen:

Name_____ 2) Name_____
Phone #_____ Phone #_____
Dates of care_____ Dates of care_____
Tests/Treatments_____ Tests/Treatments_____
Results _____ Results_____

PLEASE LIST ANY MEDICATIONS AND/OR VITAMINS YOU TAKE

What_____Frequency_____Doctor_____
What_____Frequency_____Doctor_____
What_____Frequency_____Doctor_____

OCCUPATIONAL INFORMATION

Job Involves: □ Sitting □ Standing □ Desk □ Counter □ Other _____ How long? _____
□ Lifting How much weight? _____ □ Bending □ Stooping □ Twisting □ Turning
Type of shoes □ High heels □ Boots □ Arch supports □ Other_____
How long do you speak on the telephone each day? _____ □ Traditional telephone receiver □ Headset
Physical activity at work: □ Sedentary □ Light manual labor □ Manual labor □ Heavy manual labor

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Prior Similar Symptoms: Has your history contributed to your current symptoms

Do any of your work activities aggravate your present main complaints? Please describe:

_____

□I have NOT had prior symptoms similar to my current complaints

□My history HAS contributed to my current symptoms

□My current complaints DID exist before, but have not been bothering me

___/___/___

□ My history HAS NOT contributed to my current symptoms

□My current complaints ALREADY existed and were worsened

□ I'm NOT SURE if my history has contributed to my current symptoms.

My most recent prior similar symptoms (if applicable) occurred…

□Months ago / □Years ago or on date:

Write in any prior symptom history, not covered above:

_____

Please check all conditions below that you currently have or have had in the past

□AIDS/HIV
□Chicken Pox
□Heartburn/Acid reflux
□Menstrual Irregularities
□Prostate Problems
□Alcoholism
□Chemical Dependency
□Heart Disease
□Migraine Headaches
□Prosthesis
□Allergies
□Constipation
□Heart Palpitations
□Miscarriage
□Rheumatoid Arthritis
□Allergy Shots
□Depression
□Hepatitis
□Mononucleosis
□Ringing in the Ears

□Anemia □Diabetes □Hernia
□Multiple Sclerosis □Sinusitis
□Appendicitis
□Diarrhea
□ Herniated Disc
□Mumps
□Sleeping Problems
□Arthritis
□Difficulty Swallowing
□Herpes
□Nervousness/Anxiety
□Thyroid Problems
□Asthma/Short of breath
□Dizziness
□High Blood Pressure
□Osteoporosis
□Tonsillitis
□Bleeding Disorder
□Eating Disorder
□High Cholesterol
□Pacemaker

□Tuberculosis
□Breast Lump
□Emphysema
□IBS
□Parkinson's Disease
□Tumors/Growths
□Bronchitis
□Epilepsy
□Kidney Disease
□Pinched Nerve
□Ulcers
□Cancer
□Glaucoma
□Liver Disease
□Pneumonia
□Upset Stomach
□Cataracts
□Headaches
□Measles
□Polio
□Vaginal Infections

Any other conditions not listed above: _____

HOW HAS THIS AFFECTED YOUR LIFE?

Circle one Have you missed work? YES NO If yes, how long?_____

Has the quality of your work been affected? YES NO Are you able to do household chores? YES NO

Has this problem interfered with your social life? YES NO

Has it interfered with spending time with family and friends? YES NO

Has it interfered with your recreational activities? (Exercise, Golf, Tennis, etc.) YES NO

Please List:_____

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Please list any other daily activities/duties that are difficult for you due to the pain you're having.

_____

_____

DISABILITY

Do you have a permanent disability rating? _____ Location_____

Date received_____Rating Percentage_____

HEALTH HABITS:

□ Smoking: _____ Packs per Week

□Alcohol: _____Drinks per Week

□ Coffee/Caffeine: _____Drinks per Week

□High Stress Level: High/ Moderate/ Low

Reason: _____

□ Other Chemical Dependencies:_____

Exercise: □None □ Moderate □ Daily

□ Heavy Sleep: Hours per night_____ Type of mattress_____ Naps_____

Do you sleep on your □Back □Side □Stomach

Please describe your sleep (ex. deep/restful, interrupted, etc.) _____

Any special diets?_____

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

_____ _____

Signature Date

Terms of Acceptance

When a patient seeks chiropractic health care and when a chiropractor accepts a patient for such care, it is essential that both are speaking and working for the same goals. Chiropractic does NOT diagnose or treat disease. Chiropractic has only one goal: To Locate, Analyze and Correct Spinal Interference to the Nervous System. The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The SUBLUXATION (spinal misalignment producing nerve interference,) in and of itself, is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment allows the body to function at its optimum level. This allows the INNATE healing power of the body to work at maximum efficiency to restore, maintain and promote natural health. WE DO NOT DIAGNOSE CONDITION(S) OR DISEASE(S) OTHER THAN VERTEBRAL SUBLUXATIONS. WE DO NOT OFFER TREATMENT OF CONDITION(S) OR DISEASE(S) OTHER THAN VERTEBRAL SUBLUXATIONS. WE PROMISE NO CURE FROM ANY CONDITION(S) OR DISEASE(S). THE CHIROPRACTIC ADJUSTMENT RESTORES LIFE AND HEALTH TO ITS FULLEST POTENTIAL!!!

I, having read the above statement and understanding it fully, do undertake chiropractic health care on this basis.

X_____ _____

Signature Date

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By signing below, I indicate that a copy of Healing Hands Chiropractic Notice of Privacy Practices has been made available to me and understand that my signature indicates my consent to the use and disclosure of protected health information by Healing Hands Chiropractic as described in that notice.

X_____ _____

Signature Date (Legal Guardian's Signature if Minor)

Notice of Privacy Practices

Healing Hands Chiropractic, is committed to maintaining the privacy of your protected health information known as (PHI), which is information about you, including demographic information, that my identify you and that relates to your past, present or future physical or mental health or condition and the care and treatment you receive from our practice. In addition, this Notice describes your rights to access and control you PHI. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice carefully and if you should have any questions or concerns about this Privacy Notice please do not hesitate to contact our privacy officer, Dr. Tracy Malton, 3 Hall Ave. Wallingford, CT 06492 203-626-9994

This office is required by law to abide by the terms of this Notice of Privacy practices as well as abiding by any other applicable state laws that may govern privacy practices and/or the scope of the practice of chiropractic. Our office may change and/or modify the terms of this Notice at any time and the new Notice will be effective for all PHI that we obtain at that time. Our office and/or doctor will provide you with a copy of our Notice of Privacy Practices and make a good faith effort to obtain your written acknowledgement of our Notice, no later than the date of your first service delivery. We will also keep you notified of any changes to our Notice of Privacy Practices and if requested by your our office will provide you with an updated copy of the same.

Uses and Disclosures of PHI: Our office many use and disclose of your PHI for health care delivery purposes, which is known as treatment, payment and health care operations (TPO). Our PHI may be used and disclosed by your doctor, our office staff and others outside of our office that are involved in our care and treatment of the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of the doctor's practice. It should be noted that even though our list of uses and disclosures of your PHI is fairly comprehensive, it is difficult to take into account each and every single possibility of how your PHI may be used or disclosed. We can assure you that your doctor and his office staff will do everything possible to maintain the confidentiality of your PHI. Listed below are some of the more common types of uses and disclosures of you PHI that our office is allowed to make without your consent and/or authorization. Any other uses and/or disclosures other than those listed below will only be made with your written authorization.

Treatment – Your PHI may be used and disclosed for the coordination or management of your health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding you of the referral of you from one health care provider to another. Payment – Your PHI may be used and disclosed for payment which encompasses the various activities of health care providers to obtain payment or be reimbursed for their services and of a health plan to obtain premiums to fulfill their coverage responsibilities and provide benefits under the plan and to obtain reimbursement for the provision of health care. Health Care Operations – Your PHI may be used and disclosed for healthcare operation for certain administrative, financial, legal and quality improvement activities that are necessary to run its business and to support the core functions of treatment and payment. Emergency Situation – Our office and/or doctor may use or disclose your PHI in an emergency treatment situation. If any emergency situation happens to arise we are not required to obtain a written acknowledgement from you or our Notice of Privacy Practices until after the emergency situation has ended. Minimum Necessary Standard – Our office and/or staff will make reasonable efforts to limit the use and disclosure of and requests for your PHI to the minimum necessary to accomplish the intended purpose. Employee Limitations – Your doctor will also limit the use and disclosure of your PHI to member of his or her workforce to this who may need access to your PHI for treatment, payment and health care operations. Public Health Purposes and Activities – Your PHI may be disclosed to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling, disease, injury or disability which would include reporting of disease or injury, reporting vital events like births or deaths and conducting public health surveillance, investigations or interventions. In addition, your PHI may be disclosed for public health activities like child abuse or neglect, quality, safety or effectiveness of a product or activity regulated by the FDA and persons at risk of contracting or spreading disease as well as workplace medical surveillance. Again, this information will be limited to the minimum amount necessary to accomplish the public health purpose. Business Associate Contract – A business associate is a person or entity that performs certain functions or activities that involve the use or disclosure of PHI on health of, or provides services to, a covered entity i.e.: health care provider, health care plan or clearinghouse. Your PHI may be used or disclosed to a business associate provided we obtain satisfactory assurances from the business associate that the business associate will safeguard your PHI it receives or creates from any misuse and will use

the information only for the purposes for which it was engaged to do and not for the business associates independent use or purposes, except as needed for proper management and administration of the business associate. Research Purposes – Your PHI may be used or disclosed for research purposes which have been de-identified and/or you have authorized the use and disclosure of your PHI. Workers' Compensation Purposes – Due to the variability among State laws the privacy rule permits disclosure of your PHI for purposes as authorized by and to the extend necessary to comply with workers' compensation laws without your authorization and no minimum necessary determination is required. Marketing Purposes – Your PHI may be used and disclosed for marketing purposes if it is in the form of a face-to face communication or a communication involving a promotional gift of minimal value by the covered entity i.e.: health care provider, health care plan or clearinghouse. Marketing is defined as making a communications about a product or service that encourages recipients of the communication to purchase or use the product or service. This type of marketing has certain exceptions, which do not require authorization for the use and disclosure of your PHI and are listed as follows: 1. A communication is not marketing if it is made to describe a health-related product or service that it provided by or included in a plan of benefits of the covered entity making the communication. 2. A communication is not marketing if it is made for treatment of the individual. 3. A communication is not marketing if it is made for case management or care coordination for an individual or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to the individual. Note: Besides for the above exceptions any other form of marketing would require your authorization to use and disclose your PHI. Personal Representative – Your PHI may be sued and disclosed, under State law, to a person who is authorized to act on your behalf in making your health care related decisions. Legal Proceedings – Your PHI may be disclosed if requested by any judicial or administrative proceedings, court order, a subpoena, law enforcement purposes etc. Miscellaneous uses and disclosures of PHI – We may use a sign-in-sheet at our front desk so our staff can easily see who is seeking care. We are allowed to use and disclose your name in the waiting room when you doctor is ready to see you. We may use and disclose your PHI to contact you to remind you or your appointment. We are also allowed to use and disclose your name and address to send you a newsletter about our practice and services we offer. In addition, we may send you information about products or services that we feel may benefit you. Patients' Rights to Access and Control their PHI: The Privacy Rule allows you certain rights with regards to your records, which are as follows: You have the right to review and receive copies of your records as it relates to your own care. Your request would have to be put in writing and the law requires that your doctor respond within 30 days of your request. In addition, your doctor is allowed to deny you access to your records, but only if it is going to cause you harm or someone else harm. If your doctor denies you access to your records the denial has to be referred to a health care review professional, which would be the privacy office who was designated. Your doctor is allowed to charge a copy fee, which should not exceed State law allowance. You have the right to request that the use and disclosure of your PHI be restricted. This means you have the right to request restrictions on how your doctor will use or disclose you PHI about treatment, payment and health care operations. Your doctor is not required to agree to your request for restriction, but would be bound by any restrictions to which you and your doctor agree on. You have the right to request to receive confidential communications from your doctor by alternative means or at an alternative location. Your doctor must accommodate your request, provided it is reasonable, and you clearly state that not doing so could endanger you. You have the right to request amendments (changes) to your records. If changes are made to your record it does not mean that your doctor will destroy his or her records or your doctor will rewrite their records it means that your doctor will add an addendum to your current records to reflect your changes. Your doctor has the right to deny or reject your request to change your records, but you have the right to submit a statement in the medical record that you disagree. Your doctor also has the right to add to the record a rebuttal statement. You have the right to receive your doctor's Notice of Privacy Practices. The law required that your doctor provide you in writing their policy on how they are protecting and using your PHI. You have the right to revoke an authorization. The revocation can be done at any time provided it is writing. There is an exception to revocation that is if your doctor has taken any action in reliance on the use or disclosure indicated in the doctor's Authorization Notice. Patient's Right to File a Complaint: If you believe, that any of your Privacy Rights have been violated by us you can file a written complaint with our Privacy Officer (please see our privacy office to obtain a complain form). Your complaint must be filed within 180 days of when you learned or should have known that the act occurred. In addition, you can also file a written complaint either on paper or electronically with the Office of Civil Rights (OCR). Please note that the Privacy law prohibits our office from taking any retaliatory actions against you.

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Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank because of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For Office Use Only

Height:_____ Weight:_____ Blood Pressure:_____/_____

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HIPAA COMPLIANCE SIGNATURE PAGE

Patient Name_____

Person/s you are ***releasing*** information to: _____

_____

Please choose one _____ Any information _____ Billing information only

Person/s ***not to release*** information to: _____

Patient or Guardian
signature_____

Print Name if Guardian_____ Date_____

A copy of complete HIPPA policy is available by request.

____Refused to sign_____